EXHIBIT J

JACK REESE v. CNH AMERICA LLC

EXPERT REPORT OF WILSETTA L. McCLAIN

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Dated: January 15, 2014

I. Scope of Engagement and Review

I was retained by the law firm of McKnight, McClow, Canzano, Smith & Radtke, P.C. in the lawsuit entitled *Reese, et al. v. CNH America LLC, et al.* to review and give my opinion on certain aspects of the Report of John F. Stahl dated October 17, 2013, in particular his opinion Number 3 relating to procedure codes.

I understand that the lawsuit of *Reese, et al. v. CNH America LLC, et al.* has to do with healthcare benefits for a class of hourly retirees who retired after July 1, 1994 and on or before May 1, 2005, their dependents and their surviving spouses. I also understand that healthcare for the persons covered by the lawsuit is provided under a network healthcare plan that was negotiated in 1998 between Case Corporation (now CNH) and the UAW.

I was asked to review Mr. Stahl's report and, in light of my experience in healthcare coding and insurance billing, to provide my opinion on his opinion Number 3 as it involves procedure codes and the significance, if any, of his statement that a "high percentage of the actual cost of medical . . . for the current plan over the period 2008 through 2012 involved procedure codes . . . that did not exist in 1998.

I was also asked to review particular Current Procedural Terminology (CPT) Codes that existed in 2012 and determine if the procedures they describe had equivalents in 1998. I understand that there were significant amounts of medical costs billed under these CPT codes during 2012.

A list of documents I reviewed in the preparation of this Report is attached as Exhibit I.

II. Education and Experience.

This Report is based on my experience and education relating to healthcare coding, a discipline that I have taught for many years.

I graduated magna cum laude from Capella University, an online university based in Minneapolis, Minnesota in December 2011 with a Ph. D in Human Services, specializing in Public Service Leadership.

I received two Masters Degrees, one in Business Administration and one in Health Care Management and Human Resource Management, summa cum laude, from Davenport University in Warren, Michigan in August 2006.

I received a Bachelor of Business Administration from Davenport University in May 2004, magna cum laude, specializing in Healthcare Administration.

I worked as a Medical Assistant at St. Johns Riverview Hospital in Detroit from November 1996 through December 1998.

In June 1998, through November 2004, I was employed at Dorsey Schools in Roseville, Michigan as an Instructor in the Medical Assistant Program. I was also the Assistant Director and the Medical Externship Coordinator.

From November 2004 through August 2005. I was an Instructor in the Medical Assistant Program and the Health Services Coordinator at Dorsey Schools Madison Heights, Michigan campus.

Since January 2005, I have been employed by Baker College in Auburn Hills as Department Chair of the Medical Assistant, Medical Administrative Assistants, Medical Billing Specialist, Coding and Phlebotomy programs.

Among the courses I have taught as an Allied Health Professional educator at Dorsey Schools and Baker College of Auburn Hills are Patient Assessment; Electrocardiography; Administration of Medication; Math for Health Occupations; Medical Terminology; Anatomy I and II; Specialty Exams; Physician Office Laboratory; Practice Management; Medical Office Procedures; Legal and Ethical Issues for Healthcare Providers; Medical Claims Processing; ICD-9 and CPT 4 Coding; Medical Billing/Coding; Minor Office Surgery; and Phlebotomy for Laboratory Professionals.

I am certified as a National Registered Certified Medical Assistant, a National Certified Insurance and Coding Specialist; a Certified Medical Biller, a National Certified Phlebotomist and a Registered Medical Assistant.

I wrote Chapter 6, entitled Procedural Coding HCPCS, of Medical Insurance - An Integrated Approach, 3rd Ed., edited by Valerius, Bayes, Newby & Seggern.

I am a member of the National Allied Healthcare Professions, the Michigan Society of Medical Assistants and the American Association of Medical Assistants. I am a testing site coordinator for graduating medical biller/coders for the National Competency Certification Testing organization and an accreditation site surveyor for the Medical Assistants Educational Review Board.

III. Opinion

I have reviewed John Stahl's report of October 17, 2013 as it relates to comparison of procedure codes used for claims for the period 2008 through 2012 with codes in existence in 1998. In my opinion, based on my professional experience, the comparison of procedure codes contained in Mr. Stahl's report does not support in any way or substantiate in any way a conclusion that the codes in existence during the period 2008 through 2012 represented medical procedures that were not being used or in existence in 2008. In fact, no such conclusion could possibly be drawn from that comparison.

IV. Bases For My Opinion

1. The Healthcare Common Procedure Coding System (HCPCS) is divided into two principal subsystems, referred to as level I and level II of the HCPCS.

Level I of the HCPCS is comprised of the Current Procedural Terminology (CPT-4) , a numeric coding system maintained by the American Medical Association (AMA). CPT-4 codes have identifiers or descriptive terms to identify such things as medical, surgical and pathology procedures and services provided, medical equipment dispensed, injections given, medications dispensed by hospitals and physicians, etc.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT-4 codes, the Level II HCPCS codes were established for submitting claims for these items. Level II Codes are designated by an initial letter followed by four digits.

2. CPT codes are five digit numerical codes, each with a description of the procedure covered by that code. The CPT Main Index and Categories are sequenced as follows:

Anesthesiology	00100 - 01999; 99100-99140
Surgery	10040 - 69990
Radiology	70010 - 79999
Pathology and Laboratory	80049 - 89399
Medicine	90281 - 99199
Evaluation and Management	99201 - 99499

3. Changes to the CPT codes are published by the AMA annually. Additions, deletions, modifications and resequencing of CPT codes are established and approved by the CPT Editorial panel sanctioned by the AMA. Medical specialty societies, individual physicians, hospitals, third-party payers and other interested parties can and do provide input for the consideration of code changes.

4. CPT codes are used by hospitals, physicians and other providers to bill third-party payers, for example health insurance companies, for their services. Changes to CPT codes can affect the coverage provided under insurance plans and pricing decisions of insurers and other third party payers.

5. CPT Codes can be changed for many reasons but additions, deletions, modifications and resequencing of CPT-4 codes occur most often for reasons of specificity and clarity in the billing process (both for the payer and the payee) and also maximize reimbursement for the provider based on services performed.

6. It is no surprise that many of the numerical codes used in recent years did not appear in the 1998 version of the CPT codes, but this has very little to do with the introduction of new medical procedures or new technology. The existence of a new CPT code is not the equivalent of a new medical procedure or new medical technology. Far more often, a new CPT code is a redefinition of an existing code or the bundling (combining procedures - to be more specific) of several separately described procedures into a single code or the unbundling (taking apart a procedure - to be more specific) of a described procedure into several separately described procedures, and/or a combination of all these actions. These actions affect billing and reimbursement practices. Sometime new codes are assigned to the exact same description of an existing procedure for the purpose of resequencing that procedure in another part of the CPT code sequence.

7. Plaintiffs' counsel have asked me to analyze ten CPT codes that I understand were assigned in 2012 to medical procedures provided to participants who are part of this Class Action. Those CPT codes are 29827; 49083; 64483; 74176, 74177, 74178; 80053; 93306; 93458 and 96413. I also understand that these codes were among the CPT codes with the highest paid total amounts in 2012 by CPT code number.

8. None of these CPT codes were in the 1998 CPT Codes. However, in each case, the procedures described by these CPT codes existed in 1998 and were covered by 1998 CPT codes. None of these ten codes described medical procedures or technology that was not in existence in 1998.

9. **2012 CPT Code 29827.** This 2012 CPT code is a surgical procedure described "Arthroscopy, shoulder, surgical; with rotator cuff repair."

Arthroscopy is not a new medical procedure. In 1998, there were at least eight CPT codes for shoulder arthroscopy, in the range from 29815 to 29826. CPT code 29827 was added in 2010 because, after some substantial revisions to arthroscopic codes in 2002, many of the existing codes needed to be revised or deleted. The addition of CPT Codes such as 29827 in 2010 and 29806 29807 and 29824 in 2002, meant that there were new codes to describe common arthroscopic shoulder surgeries that formerly had to be reported using a CPT code 29909: "unlisted procedure, arthroscopy," a code that existed in 1998. Orthopedic coders are painfully familiar with the denials, extra documentation, reimbursement reductions and other pitfalls that came with submitting this code. And as if to put those headaches to bed permanently CPT has eliminated 29909 replacing it with 29999. The change is largely symbolic as the language for 29999 remains just as it was for 29909: "unlisted procedure, arthroscopy."

Here, as elsewhere in the CPT codes, change happened not because of a new procedure but for specificity and identification of an existing procedure that was otherwise classified under another deleted code or as an unlisted procedure.

10. **2012 CPT Code 49083.** : This CPT codes is for the surgical procedure "Abdominal Paracentesis and Peritoneal Lavage." CPT codes 49082, 49083 and 49084 modified and replaced former CPT codes 49080 and 49081, CPT codes in existence in 1998 that also described abdominal paracentesis.

The prior codes, 49080 and 49081, in existence in 1998, described as "Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic), initial," and "Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic), subsequent," respectively. The new codes for abdominal paracentesis, 49082 and 49083, describe the procedure performed without or with imaging guidance. If the healthcare professional performs abdominal paracentesis without imaging guidance, the CPT code is 49082, "Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance." If abdominal paracentesis is performed with imaging guidance (regardless of the method used), CPT code 49083 "Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance," describes the procedure.

As you can see, this is not a new procedure just a more specific and identifiable CPT code for a pre-existing procedure. The change maximized the reimbursement to the provider for the described procedure if done using imaging, which was in existence long before 1998.

11. **2012 CPT Code 64483.** This CPT code describes surgical injections into the spine, specifically "Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level." 2012 CPT code 64483 describes the same procedure but is used for "each additional level." 2012 CPT code 64483 describes an injection(s) into the spine (specifically the lumbar or sacral, single level). The 2012 CPT codes 64479-64484 describe transforaminal epidural nerve blocks in the cervical or thoracic regions (64479-80, or the lumbar or sacral regions (64483-84).CPT code 64479 or 64483 are used for the first level and CPT codes 64480 or 64484 are used for each additional level.

In the 1998, CPT codes 64400 through 64530 described nerve block injections by a specific nerve and/or area where the nerve block injection was given.

Again, the codes used in 2012 did not describe a new medical procedure; they were modified to describe an already existing procedure differently for purposes of billing.

12. **2012 Codes 74176, 74177 and 74178:** In 2011, the AMA created these three new radiological CPT codes to capture instances when abdominal and pelvic CT Scans were performed at the same time, and Medicare assigned these new codes to existing Ambulatory Payment Classification. These codes are 74176, "Computed tomography, abdomen and pelvis; without contrast material; 74177; "Computed tomography, abdomen and pelvis;with contrast material;" and 74178 "Computed tomography, abdomen and pelvis; without contrast in one or both body regions, followed by contrast material(s) and further sections in one or both body regions."

In 1998, there were three CPT codes for CT Scans of the abdomen and three codes for CT Scans of the pelvis. The 1998 CPT codes were:

1998 Abdominal CT Codes:

74150 Computed tomography, abdomen; without contrast material
74160 Computed tomography, abdomen with contrast material(s)
7417 0 Computed tomography, abdomen without contrast material, followed by contrast material(s) and further sections

1998 Pelvic CT Codes:

72192 Computed tomography, pelvis; without contrast material
72193 Computed tomography, pelvis, with contrast material(s)
72194 Computed tomography, pelvis. without contrast material, followed by contrast material(s) and further sections

2012 Codes 74176, 74177 and 74178 did not describe any new medical procedures. These three codes were to be used, rather than the six 1998 CPT codes described above, on those occasions when the CT procedure was performed on both the abdomen and pelvis at the same time.

13. **2012 CPT Code 80053.** 2012 Code 80053 is a laboratory code defined as "Comprehensive metabolic panel," including the following tests, with the CPT code in paraenthesis: "albumin (82040), total bilirubin (82247), calcium (82310), carbon dioxide (bicarbonate) (82374), chloride (83435), creatinine (82565), glucose (82947), alkaline phosphatase (84075), potassium (84132), total protein (84155), sodium (84295), alanine amino transferase (ALT) (SGPT) (84460), aspartate amino transferase (AST) (SGOT) (84450), and urea nitrogen (BUN) (84520). Blood specimen is obtained by venipuncture. See the specific codes for additional information about the listed tests."

In 1998, CPT code 80054 was described as Comprehensive Metabolic Panel which "must include the following: Albumin (82040), Bilirubin total OR direct (82250), Calcium (82310), Chloride (82435), Creatinine (82565), Glucose (82947), Phosphatase, alkaline (84075), Potassium (84132), Protein, total (84155), Sodium (84295), Transferase aspartate amino (AST) (SGOT) (84450), and Urea nitrogen (BUN) (84520)."

2012 Code 80053 is not a new medical procedure. It includes two extra blood tests, carbon dioxide - bicarbonate (82374) and alanine amino transferase (ALT) (SGPT) (84460), both of which have the same CPT codes in 2012 as they did in 1998. In 1998, carbon dioxide - bicarbonate (82374) was included in the Electrolyte panel, CPT code 80051, and alanine amino transferase (ALT) (SGPT) (84460) was included in the Hepatic function panel, CPT Code 80058.

14. **2012 CPT Code 93306.** 2012 CPT code 93306 is "Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography."

In 1998, CPT Code 93350 was for: " Echocardiography, transthoracic, real-time with image documentation (2D, with or without M-mode recording), during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report." In 1998, under the Medicare Outpatient Prospective Payment System(OPPS), the technical components of "add-on" codes +93320,+93321 and +93325 are listed as packaged services. When these services were provided in the outpatient department, the payment for the "add-on" services is included in the reimbursement for the 2D echocardiography service. Code 93325 was to report a color Doppler examination of the flow of blood through the heart's chambers and valves in addition to existing codes for 2D echocardiography, including CPT code 93350. It was not to be reported

separately, but could be used in conjunction with echocardiography codes 93308 and 93350, among others.

2012 CPT Code 93306 was not a new medical procedure, but a modification of the codes that described those same procedures in 1998.

15. **2012 CPT Code 93458.** 2012 CPT code 93458 is "Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed." This code was implemented in 2011 and replaced several other codes that were being used to identify the same catheter placement services described in that code.

Prior to 2011, and going back to before 1998, the medical procedure of catheter placement in a coronary artery for coronary angiography was fully described in CPT codes. For example, in 1998, CPT code 93508 described: "Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization." Code 93508 bundled into CPT code 92980, described as "Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel." 1998 CPT codes 93510, 93511 and 93514 described left heart catherization; CPT codes 93524, 93527, 93528 and 93529 described combined heart catherizations; and 1998 CPT codes 93543, 93545, 93555 and 93556 described injection procedures and imaging supervision during cardiac catherizations.

In essence, prior to the 2011 CPT code change, reporting the procedures described in CPT code 93458 required the use of several codes for billing purposes. After the change in 2011, billing under a single CPT code sufficed and made it unnecessary to use the multiple described above.

16. **2012 CPT Code 96413.** 2012 Code 96413 is defined as "Chemotherapy administration, intravenous infusion technique, up to one hour, single or initial substance." For the first 15 minutes, up to the first hour of chemotherapy infusion, this CPT code must be used for a single or initial chemotherapeutic medication. CPT codes 96415 describes chemotherapeutic infusions greater than an hour given and must be billed in addition to CPT code 96413 for the initial infusion.

The relevant CPT code for the chemotherapy intravenous infusion procedure in 1998 was 96410: "Chemotherapy administration, intravenous; infusion technique, up to one hour." The 1998 CPT code for infusions greater than one hour was 96412: "Chemotherapy administration, intravenous infusion technique, each additional hour, one to eight (8) hours (List separately in addition to code for primary procedure)."

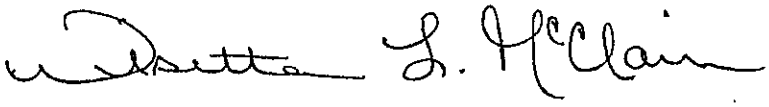
1998 CPT code 96410 described the same medical procedures described in 2012 CPT code 96413 and 96409. According to he Center for Medicare and Medicaid Services website, the changes to the codes were made for reporting mishaps and reimbursement processes.

17. Coding procedures, identified procedural coding information, and CPT-4 codes can be viewed and downloaded at the Center for Medicare and Medicaid website (cms.gov) and/or can be found in the published AMA CPT-4 manuals for the years 1998 through 2012.

Wilsetta McClain Digitally signed by Wilsetta McClain
DN: cn=Wilsetta McClain, o=Baker College, ou=Health Sciences, email=zmccla01@baker.edu, c=US
Date: 2014.01.15 15:39:16 -05'00'

Wilsetta L. McClain

Dated: January 15, 2014



COMPENSATION

The fee for my services relating to the preparation of this report is based on a rate of $150 per hour. I have spent approximately 21 hours on this matter. I have not yet billed for my services.